

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

05941

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH

County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 hours.
 Hospital, institution, or street address where death occurred
 Union Pop. Elktion Md.
 How long in hospital or institution? 7 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Pa..... County..... Chester
 City or town..... West Chester
 (If outside city or town limits, write RURAL and give nearest town)
 Street..... 5th and Parkville
 (If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Isabella Marie Audrien

3. (b) Social Security Number

4. Sex..... F.....
 5. Color or race..... White
 6. (a) Single, married, widowed, or divorced..... Divorced.
 6. (b) Name of husband or wife..... Edmund. Drigley
 6. (c) If alive, give age..... 37 years
 7. Birth date of deceased (mo., day, yr.)..... May 16 1912.
 8. AGE: Years..... 35..... Months..... 2..... Days..... 12..... hrs..... min.

9. Birthplace..... Philadelphia Pa.
(Town, county, and state)

10. Usual occupation..... Housewife.

11. Industry or business

12. Name..... James J. Audrien

13. Birthplace..... Ardmore Pa.

14. Maiden name..... Veronica E. O'Neill

15. Birthplace..... Philadelphia Pa.

16. Informant..... Mrs. J. J. Audrien

Address..... 5th and Parkville Md.

17. Removal..... Date thereof..... July 28 1947

(Burial, cremation, or removal. Which?)

Cemetery or crematory..... St Dennis

Location..... South Ardmore, Pa.

18. Funeral director..... J. W. Hession

Address..... Elktion Md.

19. July 28 1947..... J. F. Frazier

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 28 1947.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

For fracture of base of skull.

Due to..... Compound.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of..... 7/27-47

Where did injury occur..... Elktion Popul. Cecil Md.

(City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where)..... Blair Shore.

Means of injury..... Fall down bank Injured at work?

Medical Examiner.....

23. SIGNATURE..... J. L. Roddion

M. D. or other.....

Address..... Union 9 Summit Date signed..... 7/28-47



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

05942

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH: Cecil
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
 Union Hospital
 How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Cecil
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
 Father Basil Benz

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) June 28 1881

8. AGE: 66 Years 11 Months - Days If less than one day hrs. min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Religious Director

11. Industry or business

12. Name no information

13. Birthplace Germany

14. Maiden name no information

15. Birthplace Germany

16. Informant Father Walter Herborn

Address Elcton Md

17. Burial Date thereof July 30 1947

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Divine Saviors Cemetery

Location Fawnham Maryland

18. Funeral director H. W. Bissinger

Address Elcton Md

19. July 29 1947 J. H. Trager

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1947 at 5:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1947 to July 28 1947 and that I last saw him alive on July 27 1947

Immediate cause of death Coronary Thrombosis

Due to.....

Due to.....

Other conditions Myocardial Failure July 1
 (Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

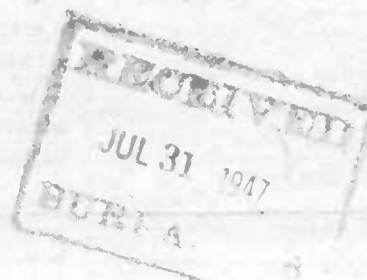
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. J. H. Trager

Address Elcton Md Date signed July 28 1947



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 181

05943

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County ecil
City or town Elkton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 hours

Hospital, institution, or street address where death occurred

Elkton Hosp. Elkton IndHow long in hospital or institution? 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County ecilCity or town North East Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Ann. Cameron

3. (b) Social Security Number

4. Sex

F.

5. Color or race

Wh.

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) March 1, 1938

8. AGE: Years Months Days If less than one day

845

hrs. min.

9. Birthplace Elkton Ind
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name William Cameron13. Birthplace North, East, Ind14. Maiden name Ann Holmes15. Birthplace Elkton P.D. Ind16. Informant Mrs Margaret O'ConnorAddress Elkton P.D. 1, Ind17. Burial Date thereof July 7, 47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory North EastLocation North East Ind18. Funeral director H.W. PippinAddress Elkton, Ind19. July 7, 1947

(Date rec'd by registrar)

J.R. Fraser

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4, 1947 at 8:25 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death Blind drops
burn of
exterior body.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7-4-47Where did injury occur Elkton Rural Cecil Ind
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Household Expt. Injured at work? no

Medical Examiner _____

23. SIGNATURE R. L. DeLeonardis _____Address Elkton Ind M. D. or other _____ Date signed 7-5-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

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JUL 8 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 181

CERTIFICATE OF DEATH

05944

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil
 City or town Elkton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 hours
 Hospital, institution, or street address where death occurred:
Union Hosp. Elkton Md
 How long in hospital or institution? 8 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Cecil
 City or town North East Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Wm A. Cameron

3. (b) Social Security Number

216-05-6579

4. Sex

M

5. Color or race

Wh

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Anna Mae Cameron6. (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.)

May 2, 1914

8. AGE:

Years 33 Months 2 Days 2 It less than one day _____ hrs. _____ min.

9. Birthplace

North East, Md
(Town, county, and state)

10. Usual occupation

North East Fire Brick Co

11. Industry or business

FATHER

12. Name

William Cameron

13. Birthplace

North East, Md

14. Maiden name

Clara Weaver

15. Birthplace

North East, Md

16. Informant

Margaret O'Brien

Address

Elkton R.D. 1, Md

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

July 7, 1947
(month) (day) (year)

Cemetery or crematory

North East

Location

North East, Md

18. Funeral director

H W Pippin

Address

Elkton, Md19. July 7 19 47

(Date recd by registrar)

F H Srazer

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 5, 1947, at 12:09 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____, and that I last saw him _____ alive on _____ 19____.

Immediate cause of death

90% fluid
degrease burn
of body.

DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7-4-47
 Where did injury occur? Elkton Rural Cecil Md
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

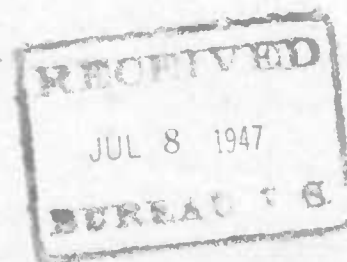
Home

Injured at work?

no

23. SIGNATURE

R L Dogdon MD Medical Examiner
Cecil County
Dean S. Sear MD M. D. or other
 Address _____ Date signed 7-5-47



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

05945

CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH:

County Cecil

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil

City or town Earlsville Rural

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Jane Duff

3. (b) Social Security Number

none

4. Sex

F.

5. Color of race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Thomas Duff

7. Birth date of deceased (mo., day, yr.)

July 4 1861

6. (c) If alive, give age years

8. AGE:

Years 85

Months

Days

If less than one day

hrs. min.

9. Birthplace

Cecil Md

10. Usual occupation

Housework

11. Industry or business

MOTHER FATHER

12. Name

Lambert Cutler

13. Birthplace

Md.

14. Maiden name

Lillian Riley

15. Birthplace

Pa.

16. Informant

William Walmsley

Address

Rural Earlsville Md.

17. (Burial, cremation, or removal. Which?)

Date thereof July 5 1947

Cemetery or crematory

Baltimore

Location

Baltimore and

16. Funeral director

Chapman

Address

Millington Md.

19. July 5 - 1947

(Date rec'd by registrar)

1947 Mrs. Thomas W. Chapman

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1947 at 104

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

Chronic Myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. P. Dockery

Medical Examiner

Cecil County

M. D. or other

Date signed 7-2-47

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JUL 7 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Bates

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

922

05946

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
 147 E. Main St.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Md..... County..... Cecil
 City or town..... Elkton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 147 E. Main St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

William Sterling Evans

3. (b) Social Security Number

4. Sex M 5. Color or race wh. 6. (a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife Adelaide Ford Evans

7. Birth date of deceased (mo., day, yr.) November 1, 1879

8. AGE: Years 67 Months 8 Days 28 If less than one day hrs. min.

9. Birthplace Elkton, Cecil Co. Maryland (Town, county, and state)

10. Usual occupation Insurance

11. Industry or business

12. Name William Steel Evans

13. Birthplace Cecil Co. Maryland

14. Maiden name Jennie Frazer

15. Birthplace Maryland

16. Informant Mr. Stanley Evans

Address Elkton, Md.

17. Burial Date thereof July 31-1947

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Elkton

Location Elkton, Md.

18. Funeral director H.W. Pippin

Address Elkton, Md.

19. July 30 47 F. R. FRAZER Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1947 8:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1925 to July 29 1947

and that I last saw him alive on July 29 1947

Immediate cause of death Cerebral Embolus

Chronic Endocarditis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

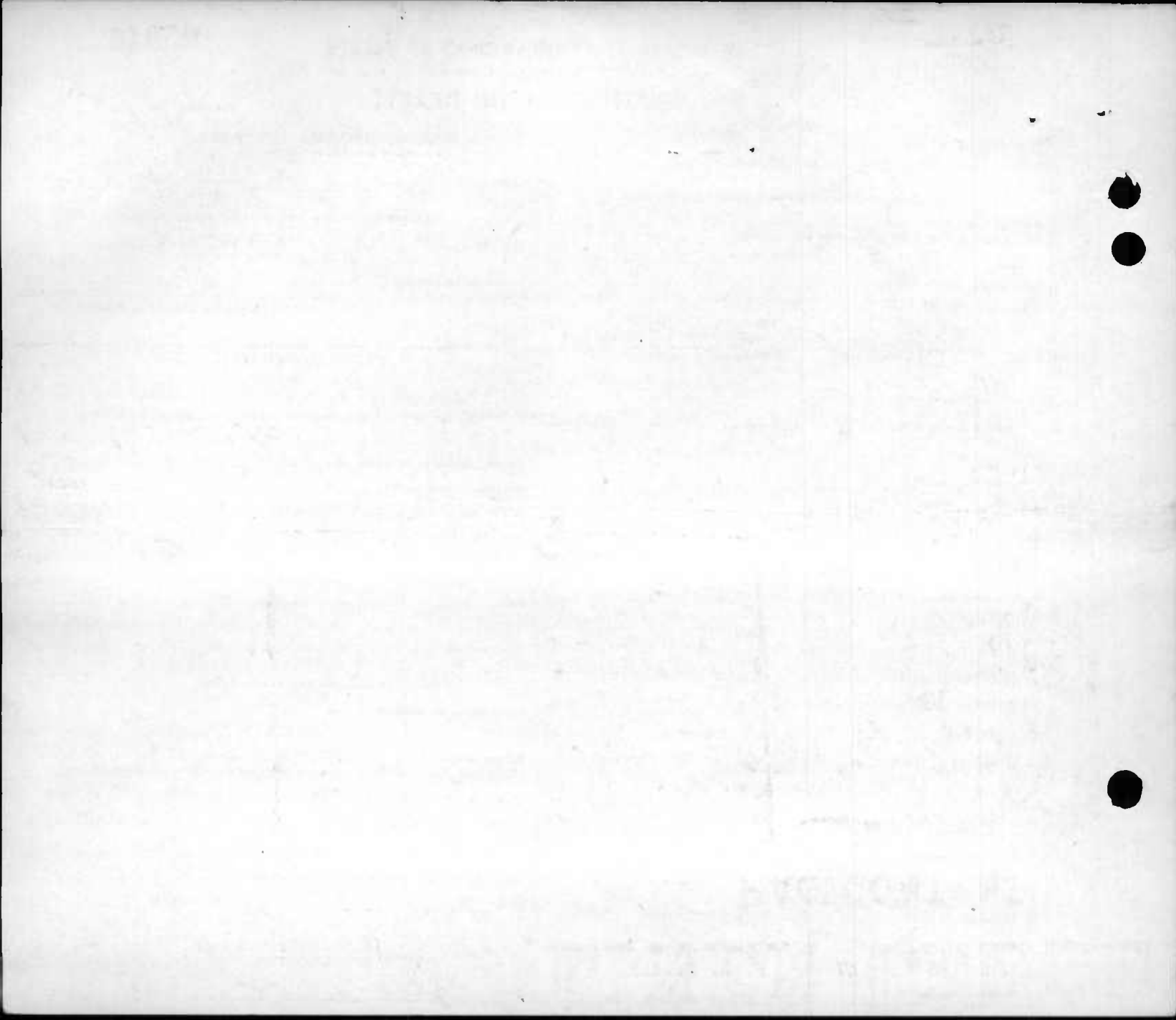
Means of injury Injured at work?

23. SIGNATURE

Address Elkton, Md.

Date signed 7/29/47

Address



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

CERTIFICATE OF DEATH

Reg. Dist. No.

Mary E. Frater
05947

1. PLACE OF DEATH:

County... Cecil

City or town... Elkton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... Cecil

City or town... Chesapeake City, Md
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Mary E. Frater

3. (b) Social Security Number

4. Sex

F.

5. Color or race

Wh

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Richard Frater

7. Birth date of

deceased (mo., day, yr.)

Aug 25, 1857

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

89

11

29

.....hrs.

.....min.

9. Birthplace

Lindisville, Pa

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

MOTHER FATHER

12. Name

Israel Collier

13. Birthplace

Pa

14. Maiden name

No Information

15. Birthplace

16. Informant

James R. Frater

Address

Chesapeake City, Md

17.

(Burial, cremation, or removal Which?)

Date thereof

Aug 2/47
(month) (day) (year)

Cemetery or crematory

Bethel

Location

Near Chesapeake City, Md

18. Funeral director

H W Pippin

Address

Elkton, Md

19.

(Date rec'd by registrar)

Aug 7, 1947

J R Frager

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 31

19.

47

at

7 3/4

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 28, 1947 to July 31, 1947

and that I last saw him alive on

July 30, 1947

Immediate cause of death

Cerebral hemorrhage

Due to

Hypertension C.T.D. disease

Due to

several years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Chesapeake City, Md

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

at home fear no

Means of injury

fell up stairs

Injured at work

25 stairs

23. SIGNATURE

Thos J Davis Md

M. D. or other

Address

Chesapeake City, Md

Date signed

8/1/47

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VS A15

9-45-15M

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1318

CERTIFICATE OF DEATH

Reg. Diat. No. 05948

1. PLACE OF DEATH:

County Cecil
 City or town Elkton, Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
E High St Elkton, Md
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Cecil
 City or town E High St Elkton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 222
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War #1

3. (a) FULL NAME

Cilfred Goodnow

3. (b) Social Security Number

218-01-1657

4. Sex M 5. Color or race Wh 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Elsie Goodnow
 7. Birth date of deceased (mo., day, yr.) June 26, 1898 6.(c) If alive, give age 48 years
 8. AGE: Years 49 Months 0 Days 28 It less than one day hrs. min.

9. Birthplace North East, Md
 (Town, county, and state)
 10. Usual occupation Maintenance Man
 11. Industry or business Springs Pt, Md
 12. Name William Goodnow
 13. Birthplace North East Md
 14. Maiden name Margaret Harding
 15. Birthplace Bucks Co. Pa.

16. Informant Mrs Elsie Goodnow
 Address 140 E High St Elkton, Md
 17. Burial, cremation, or removal, Which? Burial Date thereof July 26/47
 (month) (day) (year)
 Cemetery or crematory Elkton
 Location Elkton, Md
 18. Funeral director H.W. Kippard
 Address Elkton, Md
 19. July 26 19 47 Registrar FR Mason
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 19 47 at P. 354 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 6 19 46 to July 24 19 47
 and that I last saw him alive on July 24 19 47

Immediate cause of death Cerebral Regurgitation
 DURATION 3 yrs.

Due to

Due to

Other conditions Chronic paraneuritis
Arthritis
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE James L. Johnson M.D.Address 232 C. H. St, Elkton, Md Date signed 7/26/47

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. MARITAL STATUS

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESS

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF CLERGYMAN

18. SIGNATURE OF BURIAL OFFICIAL

19. SIGNATURE OF FUNERAL HOME

20. SIGNATURE OF OTHER

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JUL 28 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

05949

Reg. Dist. No. 95

1. PLACE OF DEATH:

County Cecil
 City or town Route 2 53 near Big Elk Creek
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? on road.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Cecil
 City or town Rising Sun.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Malvin Davis Grason

3. (b) Social Security Number

219-05-5037

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife. Jessie Grason.

6. (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1886

8. AGE: Years 60 Months 7 Days 9 If less than one day hrs. min.

9. Birthplace Chrome, Penna.
(Town, county, and state)

10. Usual occupation Weighmaster

11. Industry or business

12. Name George R. Grason.

13. Birthplace Md.

14. Maiden name Laura J. Grason.

15. Birthplace Chrome, Pa.

16. Informant Verna Grason

Address Rising Sun, Md.

17. Burial Date thereof July 10, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Brookside

Location Rising Sun, Md.

18. Funeral director J. E. Tyson.

Address Rising Sun, Md.

19. July 9, 47 20. Registrar

(Date rec'd by registrar) 7-9-47

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1947, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. to 19.

and that I last saw him alive on 19.

Immediate cause of death

Acute coronary thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. L. Dodson, M.D. Medical Examiner

Address Rising Sun, Md. Cecil County

Date signed 7-8-47

RECEIVED

JUL 11 1947

BUREAU 7.2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 92

1. PLACE OF DEATH: Cecil
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME Sarah J. Greenwell

3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed.
 6. (b) Name of husband or wife Robert Gib Greenwell

7. Birth date of deceased (mo., day, yr.) 1859 8. (c) If alive, give age..... years

8. AGE: 88 Years Months Days If less than one day..... hrs. min.

9. Birthplace Godrich Ontario (Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name James Black

13. Birthplace Godrich Ontario

14. Maiden name No information

15. Birthplace

16. Informant P. C. Williams

Address Elkton, Md.

17. removal Date thereof July 2 '47 (month) (day) (year)

Cemetery or crematory to Petoskey, Mich.

Location Petoskey, Michigan

18. Funeral director H. H. Babin

Address Elkton, Md.

19. July 2 19 47 J. H. Frazier Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 19 47, at 4:21 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 12 19 47 to July 2 19 47 and that I last saw him alive on July 1 19 47

Immediate cause of death Generalized arteriosclerosis
 D.I.S.

Due to.....

Due to.....

Other conditions Cerebral softening

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Richard H. Sprecher

Address Elkton, Md. Date signed July 2

M. D. or other

CERTIFICATE OF DEATH

RECEIVED

JUL 5 1947

BUREAU 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05951

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil
City or town Elkton R.D. 4 Pleasant Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

City or town Elkton R.D. 4 Pleasant Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Jamie Grubb

3. (b) Social Security Number

217-09-1437

4. Sex M. 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Margaret Grubb

7. Birth date of deceased (mo., day, yr.) January 1, 1888

8. AGE: Years 59 Months 6 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Wilmington, Del.
(Town, county, and state)

10. Usual occupation Leather worker

11. Industry or business _____

12. Name William Grubb

13. Birthplace Delaware

14. Maiden name Margaret Beaton

15. Birthplace Delaware

16. Informant Jamie Grubb

Address 649 - 74th St Brooklyn N.Y.

17. Burial Date thereof July 26/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Elkton

Location Elkton, Maryland

16. Funeral director H.W. Phipps

Address Elkton, Md.

19. July 26 19 47 F. R. Frazer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 19 47 at 1040 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Shot gun left side of chest.

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accidental See over 7/24-47
Accident, suicide, or homicide Date of _____
Where did injury occur Elkton Rural Circle Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury 12 gauge Shot Gun Injured at work? no

23. SIGNATURE Dr. J. R. Doctson Medical Examiner
for Cecil County
M. D. or other _____

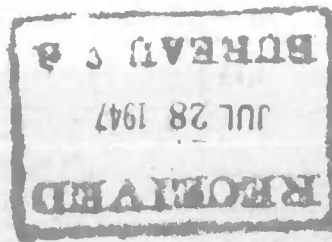
Address Elkton, Md. Date signed _____

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Changed from Suicide to "Accidental" on statement of Dr. R.C. Dodson, received in this office July 31, 1947 as follows: "I wish this to be changed to accidental death. I ask the above to be changed because I have no positive proof that it was suicide, but do have proof that it was not homicide." 7-31-47 ams



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 132

CERTIFICATE OF DEATH

Reg. Dist. No. 05952

1. PLACE OF DEATH:

County Baltimore
City or town Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death from May 29 to July 25 - 47
Hospital, institution, or street address where death occurred United Hospital
How long in hospital or institution? 2 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Anne Arundel Md County Besie
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Amanda Harris
4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Owen Harris
6. (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 12 1883

8. AGE: 54 Years 13 Months 13 Days If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Taylor Moore

12. Name Maryland

13. Birthplace Hannal R. Pierce

14. Maiden name Maryland

15. Birthplace The deceased

16. Informant Burial

Address 7-28-47

17. (Burial, cremation, or removal. Which?) Burial Date thereof 7-28-47
(month) (day) (year)

Cemetery or crematory Great Nottingham

Location Elkton Md.

18. Funeral director Ralph Reed

Address Rising Sun Md

19. July 27 1947 JR Inazer
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26th 1947 at 7:00 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 1947 to July 26 1947
and that I last saw her alive on July 25 1947
Immediate cause of death Myocardial infarction about 3 weeks

Due to Diabetes hypertension & suppression of urea 34 yrs

Due to Old chronic indigestion continued
Other conditions General arteriosclerosis old
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. A. M. Wright M.D.
M. D. or other

Address July 26 47 Elkton Md. Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 30 1947
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

05953

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH:

County CecilCity or town North East
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County CecilCity or town North East md
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Bertha A Harrison

3. (b) Social Security Number

none4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife William Harrison7. Birth date of deceased (mo., day, yr.) November 7 18 728. AGE: Years 74 Months 8 Days 14 Less than one day _____ hrs. _____ min.9. Birthplace North East Cecil Co Md
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name Samuel R White13. Birthplace md14. Maiden name Mary H. Loalman15. Birthplace md16. Informant Mrs Hilda FoundsAddress North East, md17. Burial Date thereof July 31 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory MethodistLocation North East, md18. Funeral director Joseph R. FrankAddress North East, md19. 7-31- 19 47 Lidia V. Owens
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 19 47 at 10:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death legerebral hemorrhageDue to hemorrhage

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Paul D. Dodson Medical ExaminerAddress Prisington Md. M. D. or other _____Date signed 7-31-47

RECEIVED
AUG 2 1947
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05954

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil
 City or town Elkton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 hrs.
 Hospital, institution, or street address where death occurred:
Union Hospital
 How long in hospital or institution? 3 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Ind. County Cecil
 City or town Chesapeake City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Claude Holmes

3. (b) Social Security Number

4. Sex M. 5. Color or race wh 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) June 23, 1947
 8. AGE: Years _____ Months 1 Days 7 If less than one day _____ hrs. _____ min.
 9. Birthplace Chesapeake City
 (town, county, and state)

10. Usual occupation _____
 11. Industry or business _____

MOTHER FATHER
 12. Name Burton Holmes
 13. Birthplace Elkton R.D. Ind
 14. Maiden name Corrie Ruthwell
 15. Birthplace Elkton Ind

16. Informant Burton Holmes
 Address Chesapeake City Ind
 17. Burial Date thereof July 31/47
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Elkton
 Location Elkton Ind

18. Funeral director H.W. Lippin
 Address Elkton Ind

19. July 30 1947 FR Frazier
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1947, at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____, and that I last saw him _____ alive on _____ 19____.

Immediate cause of death Lobar Pneumonia

Due to _____
 Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE R. L. Dockson Medical Examiner
Rising Sun Ind Cecil County
 M. D. or other _____
 Address _____ Date signed 7/30-47

IN 26. 1947

RECEIVED

RECEIVED
AUG 1 1947
BUREAU OF

RECEIVED
AUG 1 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 181

05955

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Elkton
 City or town Elkton
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hours
 Hospital, institution, or street address where death occurred: Union Hospital Elkton, Md
 How long in hospital or institution? 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Elkton
 City or town Elkton R.D. I
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Ruth Ann Holmes

3. (b) Social Security Number

4. Sex F. 5. Color or race Wh. 6.(a) Single, married, widowed, or divorced Single.

6.(b) Name of husband or wife _____

6.(c) It alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb. 2 19458. AGE: Years 2 Months 5 Days 2 If less than one day _____ hrs. _____ min.9. Birthplace Elkton, Md
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Raymond Holmes13. Birthplace Elkton R.D. 1 Md14. Maiden name Martha Bullock15. Birthplace Elkton, Md16. Informant Martha Margaret O'ConnerAddress Elkton R.D. 1 Md17. Burial Date thereof July 7 / 47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Elkton, MdLocation Elkton, Md18. Funeral director H.W. PippinAddress Elkton, Md19. July 7 19 47 J.H. Frazee
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 19 47 at 9:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Third degree burn of entire body

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7-4-47Where did injury occur? Elkton R.D. I Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Gasoline Explor. Injured at work? no

Medical Examiner _____

County _____

23. SIGNATURE R.L. Dockrath M.D. or other _____Address Elkton, Md Date signed 7-5-47

RECEIVED
JUL 8 1947
BUREAU I. C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05956

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Pearl
City or town Perryville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 mos.
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Lillian A. Mc. Slaughter

3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Walter D. Mc. Slaughter

7. Birth date of deceased (mo., day, yr.) May 17, 1902 8. (c) If alive, give age 46 years

8. AGE: Years 45 Months 1 Days 24 If less than one day hrs. min.

9. Birthplace Laurens Co., Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business George Cox

12. Name George Cox

13. Birthplace Pa.

14. Maiden name Mary Stoner

15. Birthplace Pa.

16. Informant Mrs. Jean Winchester

Address Perryville, Md.

17. Burial July 14, 1947
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematorium St. Pleasant

Location Christiana - Pa.

18. Funeral director Lee A. Patterson & Son

Address Perryville, Md.

19. July 11, 1947 Irene E. Slaughter
(Date rec'd by registrar) (Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Penna County Chester
City or town Perryville
(If outside city or town limits, write RURAL and give nearest town)
Street No. ✓
(If rural, give LOCATION)
2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 JULY 19 47, at 2:25 A.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from 11 July 19 47, to 2:30 AM 11 July 19 47, and that I last saw her alive on 11 July 19 47.

Immediate cause of death Cardiac and Respiratory Failure

Due to Coronary Thrombosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Sadowsky
M. D. or other MD
Address Perryville, Md. Date signed 11 July

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 12 1947
BUREAU C B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 958

CERTIFICATE OF DEATH

Reg. Diat. No. 95

1. PLACE OF DEATH:

County Cecil Co.
 City or town Rising Sun Md. Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Cecil
 City or town Rising Sun Md. Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Masie Meaders

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife John H. Meaders
 6. (c) If alive, give age 40 years
 7. Birth date of deceased (mo., day, yr.) Aug 6 1911
 8. AGE: Years 35 Months 11 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Va.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Rush C. Webb13. Birthplace Va.14. Maiden name Laura Reeder15. Birthplace Va.16. Informant John H. MeadersAddress Rising Sun, Md.17. Rural Date thereof July 21, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory West NottinghamLocation Colona Md.18. Funeral director E. E. TysonAddress Rising Sun, Md.19. July 19 47 Registrar(Date rec'd by registrar) 19. 7-19-47

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 19 47, at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19 46 to 7-18 19 47
 and that I last saw h. or alive on 7-18 19 47

Immediate cause of death Pulmonary Edema DURATION 2 weeks

Due to Cardiac Decompensation 2 weeks

Due to Rheumatic Heart Disease 20 yrs.

Other conditions _____

(include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank H. Riffe MD M. D. or otherAddress Oxford, Pa. Date signed 7/19/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 22 1947
BUREAU F. B. I.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05958

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County.....Cecil
 City or town.....Perry Point, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....25 days.
 Hospital, institution, or street address where death occurred:
Veterans Administration
 How long in hospital or institution?.....25 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....Dist. Columbia County.....-
 City or town.....Washington, D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....2134 G. Street, N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....World War I

3. (a) FULL NAME

MECKS, Spurgeon NMI

3. (b) Social Security Number

4. Sex.....Male 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....Married
 6.(b) Name of husband or wife.....Myrtice Meeks
 6.(c) If alive, give age.....52 years
 7. Birth date of deceased (mo., day, yr.).....February 16, 1889
 8. AGE: Years.....58 Months.....4 Days.....18 if less than one day..... hrs. min.

9. Birthplace.....Nicholls - Coffee - Georgia
 (Town, county, and state)
 10. Usual occupation.....Clerk
 11. Industry or business.....Public Buildings Admn.
 12. Name.....Hymrick M. Meeks
 13. Birthplace.....Nicholls, Ga.
 14. Maiden name.....Mattie Hall
 15. Birthplace.....Nicholls, Ga.

16. Informant.....Mrs. Myrtice Meeks - wife.
 Address.....2134 G. St., N.W., Wash. 7, D.C.
 17. Burial.....Burial Date thereof.....7 8 47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory.....Arlington National
 Location.....Ft. Myers, Vir.

18. Funeral director.....PENNINGTON & SON
 Address.....HAYRE DE GRACE, Md.

19. Date rec'd by registrar.....July 5, 47 Registrar.....James E. Douglas

MEDICAL CERTIFICATION

20. DATE OF DEATH.....July 4, 1947 at 11:55 AM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 9, 1947, to July 4, 1947
 and that I last saw him alive on July 4, 1947

Immediate cause of death.....Subdural hemorrhage from Middle Meningeal Artery
 DURATION.....11 Hours

Due to.....Arteriosclerosis, generalized DURATION.....30 Mos.

Due to.....
 Other conditions.....Post-traumatic cystic degeneration of right frontal lobe. 47 years.
 (Include pregnancy within 8 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....Confirms above.
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....

23. SIGNATURE.....A. E. Trollinger
A.E. TROLLINGER, M.D., Clinical Director
 Address.....Veterans Administration
Perry Point, Md.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 7 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310

05959

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County... Cecil

City or town... Elkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 49 years

Hospital, institution, or street address where death occurred:

240 E. High St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Cecil

City or town... Elkton
(If outside city or town limits, write RURAL and give nearest town)Street No. 240 E. High
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Albert Minkus

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife... Gertrude Minkus

7. Birth date of deceased (mo., day, yr.)

Nor 29, 1922

6.(c) If alive, give age 74 years

8. AGE:

Years

Months

Days

If less than one day

74

7

18

hrs.

min.

9. Birthplace... North East, Cecil, Md.
(Town, county, and state)

10. Usual occupation... Signalman

11. Industry or business

FATHER

12. Name... Abraham Minkus

13. Birthplace... North East, Md.

MOTHER

14. Maiden name... Mary Harrall

15. Birthplace... Media, Pa.

16. Informant... Harry Minkus

Address... 240 E. High St, Elkton, Md.

17. Burial
(Burial, cremation, or removal. Which?)Date thereof... July 21, 1947
(month) (day) (year)

Cemetery or crematory... Elkton

Location... Elkton, Maryland

18. Funeral director... H. W. Phipps & Son, Inc. W. G. Lusk

Address... Elkton, Maryland

19. July 21, 1947
(Date rec'd by registrar)R. F. Frazer
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... July 18, 1947, at 5 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 15, 1946, to July 18, 1947

and that I last saw him alive on July 15, 1947

Immediate cause of death... Uremia poisoning

Due to... Chv. interstitial nephritis

Due to

Other conditions... Paralysis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE... James L. Johnson M.D.

M. D. or other

Address... Elkton, Md. Date signed July 19, 1947

CERTIFICATE OF DEATH

REGISTRATION DISTRICT

REGISTRATION DISTRICT

MEDICAL EXAMINATION

RECEIVED

JUL 23 1947

BURMAN 9 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 126

05960

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County **CECIL**
 City or town **Perry Point, Maryland**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **20 yrs. 9 mos. 19 days**
 Hospital, institution, or street address where death occurred:
VAH, Perry Point, Maryland
 How long in hospital or institution? **8 years and 9 months**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State **Unknown** County **Unknown**
 City or town **Unknown**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **Unknown**
 (If rural, give LOCATION)
 2. (a) If veteran, name war **World War I**

3. (a) FULL NAME

WILFRED ROWLAND MOTLEY

3. (b) Social Security Number

Unknown

4. Sex **Male** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Single**

6. (b) Name of husband or wife **—**

7. Birth date of deceased (mo., day, yr.) **March 26, 1878** 6. (c) If alive, give age **—** years

8. AGE: Years **69** Months **3** Days **18** If less than one day **—** hrs. **—** min.

9. Birthplace **England**
 (Town, county, and state)

10. Usual occupation **Draftsman**

11. Industry or business **—**

12. Name **Unknown**

13. Birthplace **Unknown**

14. Maiden name **Unknown**

15. Birthplace **Unknown**

16. Informant **Hospital Records**

Address **VAH, Perry Point, Md.**

17. **Removal** Date thereof **7-14-47**
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory **Baltimore National Cemetery**

Location **Baltimore, Maryland**

18. Funeral director **Burroughs & Son**

Address **Home in Grovet Md.**

19. **July 18** 19 **47** **Irvin E. Blough**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **July 14** 19 **47** at **2:20A**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **September 25** 19 **26** to **July 14** 19 **47**
 and that I last saw him alive on **July 14** 19 **47**

Immediate cause of death **Pancreatitis acute, hemorrhagic** DURATION **4 hours**

Due to **Biliary calculi, multiplet obstruction of common duct** unknown

Due to **—**

Other conditions **Arteriosclerosis, generalized** unknown
 (Include pregnancy within 3 months of death)

Major findings of operations **—** Date of op. **—**

Autopsy results **Same as above**
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide **—** Date of **—**

Where did injury occur? **—** (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) **—**

Means of injury **—** Injured at work? **—**

3. SIGNATURE **Reed Dodson** Medical Examiner
Cecil County
 M. D. or other **—**

Address **Perry Point Md** Date signed **7-14-47**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 16 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

05961

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
 City or town Port Deposit, Md. Rural
 (If outside city or town limits, write RURAL and give nearest town)
20 Years
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil
 City or town Port Deposit, Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Grace E. Musselman

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Norman Musselman
 7. Birth date of deceased (mo., day, yr.) February 3, 1883
 6.(c) If alive, give age _____ years
 8. AGE: Years 64 Months 5 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace Liberty Grove, Cecil Co., Md.
 (Town, county, and state)
 10. Usual occupation House Wife

11. Industry or business

12. Name John Thomas Montgomery
 13. Birthplace Cecil Co., Md.
 14. Maiden name Anna Devenshire
 15. Birthplace Pa.

16. Informant Norman Musselman
 Address Port Deposit, Md. Rural

17. Burial Quarryville Date thereof July 23, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Quarryville, Lancaster Co., Pa.

18. Funeral director Leola Patterson & Son
 Address Perryville, Md.

19. July 22, 1947 Irene E. Dougherty
 (Date rec'd by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1947 at 8 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan - 20, 1947 to July 19, 1947
 and that I last saw him alive on July 19, 1947

Immediate cause of death Coronary Occlusion

DURATION
5 yrs.

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE B. J. Benson M.D.
 Address Port Deposit Md Date signed 7-21-47
 M. D. or other

RECEIVED
JUL 24 1947
BUREAU 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Elkton Hospital

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05962

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Kent

City or town Elkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Kent County Kent

City or town Marion
(If outside city or town limits, write RURAL and give nearest town)

Street No. Chastation - Ind
(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME

Robert Worman

3. (b) Social Security Number

4. Sex M

5. Color or race

cl.

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife (ltd) Eliza Worman

7. Birth date of deceased (mo., day, yr.) July 1 1892

8. (c) If alive, give age — years

8. AGE: Years 45 Months 0 Days 16 If less than one day — hrs. — min.

9. Birthplace Chastation
(Town, county, and state)

10. Usual occupation labour

11. Industry or business farm

12. Name Robert Worman

13. Birthplace Kent Co. Ind.

14. Maiden name Unknown

15. Birthplace —

16. Informant Mr. John Cotton Worman

Address Marion - Chastation Ind

17. Burial Date thereof 7/20/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Marion - Chastation Ind

Location Mar - Chastation Ind.

18. Funeral director Mr. V. W. W. W.

Address Chastation, Maryland.

19. July 18 1947 Dr. Frazer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1947 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 9 July 1947 to 17 July 1947

and that I last saw him alive on 17 July 1947

Immediate cause of death Heart Failure

DURATION

18 hrs

Due to typhoid fever

2 wks

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations None

Ante-mortem results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George J. Knier, Jr

Address Elkton, Ind. Date signed 18 July 47

MASSACHUSETTS DEPARTMENT OF HEALTH

OFFICE OF THE REGISTRAR

STATE OF MASSACHUSETTS

RECEIVED

JUL 21 1947

BUREAU 9 B

MASSACHUSETTS DEPARTMENT OF HEALTH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

05963

Reg. Dist. No. 96

1. PLACE OF DEATH:

County... Levitt
 City or town... Port Deposit Rural
 (If outside city or town limits, write RURAL and give nearest town)
all life
 How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Pa. County... Levitt
 City or town... Port Deposit Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

George Washington Poist

3. (b) Social Security Number

218-05-3313

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Marian H. Poist

7. Birth date of deceased (mo., day, yr.) June 7 1882
 B. (c) If alive, give age 63 years

8. AGE: Years 65 Months 1 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Colora. Md.
(Town, county, and state)10. Usual occupation Butcher

11. Industry or business _____

12. Name George Hester Poist13. Birthplace Harriaville Md.14. Maiden name Emmalice Gickles15. Birthplace Perryville Md.16. Informant George M. PoistAddress Port Deposit Md.17. Burial Date thereof July 22-1947
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory StatenwellLocation Port Deposit Md. Rural18. Funeral director Lee A. Tatterson & SonAddress Perryville, Md.19. July 22 1947 Drew E. Langley
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1947 at 10:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death _____

Acute Coronary Disease

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Lee A. Tatterson Medical ExaminerAddress Perryville, Md. M. D. or other _____Date signed 7-19-47

RECEIVED
JUL 24 1947
BUREAU C B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Dist. No. 96

05964

1. PLACE OF DEATH:

County Cecil
 City or town Perry Point, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 yrs. 5 mos. 28 days
 Hospital, institution, or street address where death occurred:
VA Hospital, Perry Point, Md.
 How long in hospital or institution? Since October 1943

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4728-8th St., N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW-I

3. (a) FULL NAME

SIMPSON, Noble F.

3. (b) Social Security Number

Unknown

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mrs. Genevieve Simpson
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) August 22, 1900
 8. AGE: Years 46 Months 11 Days 0 If less than one day _____ hrs. _____ min.

9. Birthplace Washington, D.C.
 (Town, county, and state)
 10. Usual occupation Clerk- Chauffeur
 11. Industry or business _____
 12. Name Frederick M. Simpson -deceased
 13. Birthplace City Unknown (Virginia)
 14. Maiden name Rachel ? - deceased
 15. Birthplace City unknown - Virginia
 16. Informant Hospital Records

Address _____
 17. Removal Date thereof July 24, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National Cemetery
 Location Fort Myer, Virginia
 18. Funeral director Pennington & Son
 Address Havre de Grace, Maryland
 19. July 24 19 47 John Ed Langford
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 19 47 at 12:45 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 24, 19 44 to July 22, 19 47
 and that I last saw him alive on July 22 19 47
 Immediate cause of death Hemorrhage, sub-arachnoid, left DURATION 2 hrs.
 Due to Cerebral arteriosclerosis, Unknown
 Due to _____
 Other conditions Cerebral softening, internal capsule, left; Pleurisy, left with effusion (about one week) Unknown
 (Include pregnancy within 3 months of death)
 Major findings of operations _____ Date of op. _____
 Autopsy results Same as above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury -- Injured at work? _____
 23. SIGNATURE A. E. Trollinger
A. E. TROLLINGER, M.D., Clinical Director
 Address VAH, Perry Point, Md. Date signed July 23-47

RECEIVED

JUL 26 1947

BUREAU P. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05965

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
 City or town Perry Point, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 29 days
 Hospital, institution, or street address where death occurred:
VAH, Perry Point, Maryland
 How long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Virginia County _____
 City or town Rural - Alexandria
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rt. 3, Box 1
 (If rural, give LOCATION)
 2. (a) If veteran, name war World War I

3. (a) FULL NAME

CHARLES E. STANTON

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Divorced
 6. (b) Name of husband or wife _____
 7. Birth date of deceased (mo., day, yr.) June 8, 1895
 6. (c) If alive, give age _____ years
 8. AGE: Years 52 Months 1 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Alexandria, Va.
 (Town, county, and state)
 10. Usual occupation Painter
 11. Industry or business _____

12. Name Harry Washington Stanton
 13. Birthplace Alexandria, Virginia
 14. Maiden name Emma Frinks
 15. Birthplace Fairfax County, Virginia

16. Informant Hospital Records
 Address VAH, Perry Point, Md.

17. Removal Date thereof July 10, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Private Lot
 Location Alexandria, Virginia

18. Funeral director Hammond & Son
 Address Havre de Grace, Maryland

19. July 10 19 47 James E. Laughlin
 (Date recd by registrar) registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 19 47 at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11 19 47 to July 10 19 47
 and that I last saw him alive on July 10 19 47

Immediate cause of death Lobar pneumonia DURATION 36 hours

Due to Syphilis, general paralysis of the insane Unknown

Due to _____

Other conditions Arteriosclerosis, generalized Unknown
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results Same as above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE A. E. Trollinger
A. E. TROLLINGER, M.D., Clin. Director
VAH, Perry Point, Md. Date signed 7-10-47

RECEIVED
JUL 12 1947
BUREAU V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

05966

Reg. Dist. No. 92

1. PLACE OF DEATH:

County... CECIL
 City or town... ELKTON
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 4 HRS.
 Hospital, institution, or street address where death occurred:
UNION HOSPITAL.
 How long in hospital or institution?... 4 HRS.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... MARYLAND County... CECIL
 City or town... ELK MILLS
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

~~UNKNOWN~~ INFANT. John William Van Den Heuval

3. (b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced S

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1947

8. AGE: Years Months Days If less than one day
6 hrs. 48 min.

9. Birthplace ELK MILLS
 (Town, county, and state)

10. Usual occupation PREMATURE INFANT

11. Industry or business

12. Name JACOB W. VAN DEN HEUVAL13. Birthplace ELKTON, MD.14. Maiden name MARY ELIZABETH ATKINSON15. Birthplace BRIDGETON, N.J.16. Informant FATHER - JACOB VAN DEN HEUVALAddress ELK MILLS, MD.

17. Burial Date thereof July 27 '47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cherry Hill CemeteryLocation Box 10518. Funeral director Robt. J. JonesAddress Newark, Del.19. July 29, 1947 J.H. Traeger

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 JULY 1947 at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

Medical Examiner

Cecil County

M. D. or other

23. SIGNATURE R. L. Dockson King SummaAddress..... Date signed 7/27-47

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JUL 30 1947
BUREAU V.R.